IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

December 21, 2006

Lavon Rhodes, Administrator
Challis Assisted Living Facility
1050 N Clinic Rd
Challis, ID 83226-1050

License #: RC-773

Dear Ms. Rhodes:

On August 11, 2006, a state licensure survey was conducted at Challis Assisted Living Facility - Custer Hca, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact POLLY WATT-GEIER, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier, LSW

POLLY WATT-GEIER, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/slc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

August 21, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 0162

Lavon Rhodes, Administrator
Challis Assisted Living Facility
1050 N Clinic Rd
Challis, ID 83226-1050

FILE COPY

Dear Ms. Rhodes:

Based on the State Licensure survey conducted by our staff at Challis Assisted Living Facility - Custer Hca, Inc on **August 11, 2006,** we have determined that the facility failed to protect residents from inadequate care by retaining a resident for whom the facility did not have the capability, capacity, and services to provide appropriate care. The facility also failed to develop and implement the NSA for 3 of 4 residents. These failures resulted in inadequate care.

This core issue deficiency substantially limits the capacity of Challis Assisted Living Facility - Custer Hca, Inc to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **October 5, 2006. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **August 31, 2006,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**August 31, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **August 31, 2006,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 10, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Challis Assisted Living Facility.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Melanie Belnap, Program Manager, Regional Medicaid Services, Region VII - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the standard survey conducted at your residential care/assisted living facility on August 11, 2006. The surveyors conducting your survey were: Polly Watt-Geier, MSW Team Leader Health Facility Surveyor Rebecca Winter, RN Health Facility Surveyor John Wingate, RN Health Facility Surveyor Survey Definitions: UAI = Uniform Assessment Instrument NSA = Negotiated Service Agreement BMP = Behavior Management Plan MAR = Medication Administration Record mg = milligrams cm = centimeters mm = millimeters PO = By Mouth PRN = As Needed Q = every BID = twice a day	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1 review it was determined the facility retained a resident for whom the facility did not have the capability, capacity, and services to provide appropriate care (Resident #1), and the facility failed to develop and implement the NSA for 3 of 4 residents reviewed (Residents #1, #2, and #3). These failures resulted in inadequate care. The findings include: I. Acceptable Admissions Review of Resident #1's record on 8/9/06 revealed the resident was admitted on 9/27/05 with diagnoses which included congestive pulmonary disease and dementia. Further review of Resident #1's record revealed a UAI dated 10/25/05 which documented in the major problems list the resident had "something wrong" with his heel due to an injury from the Korean War. Further review of Resident #1's record revealed medical doctor and physician's assistant progress notes which documented the following: On 9/28/05 "lower extremities without edema though he does have what appears to be some skin grafting that was secondary to stepping on a phosphorous mine during Korean War." On 2/15/06 "left foot: mild generalized edema through the midfoot and around the heel. There is a 4 mm to 5 mm shallow, very tender, dry ulcer on the lateral heel." On 3/17/06 "Inspection of the left foot shows dusky looking foot, cool to the touch, 2 ulcers on the heel, 1 lateral and 1 central mid-line posterior, both of which are very tender to the touch, but no	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 2 purulent discharge. Shallow ulcers with central eschar." On 3/22/06 the resident went to the clinic for a follow up on his left heel ulcer. The authorized provider documented the resident had "severe PVD [peripheral vascular disease] with foot ulcer and lack of healing." On 7/12/06 "exam of left foot reveals two dry dark full skin thickness ulcerations in the region of the left heel, both almost 3 cm in diameter and clearly larger than what we had seen last Winter." Resident #1's record contained monthly nursing assessments, in which the following was documented: On 1/24/06 "bottom of left foot is swollen and discolored," and the resident is using a wheel chair because he cannot walk due to foot pain. On 2/17/06 "bottom of left foot is swollen, discolored rough, and has two dark areas." On 3/20/06 "left heel remains a concern, very hard, large area that is white with dark area in center." On 5/16/06 "two dollar-sized lesions on heel area that have black centers." On 6/27/06 "two lesions on heel generally red,'proud-looking,' swollen." On 8/9/06 at 10:45 a.m. Resident #1 was observed lying on his bed in his room. The resident removed his sock from his left foot to show his left heel wounds. There were two circular wounds. Both wounds had black scabs	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 3 that were sunken into the wounds below the level of the healthy skin. The larger wound was midline on the lower part of the heel and measured 3.5 cm in diameter. The second measured 2.5 cm and was located beside the first and toward the lateral aspect of the heel. On 8/9/06 at 11:05 a.m. Resident #1 stated he could no longer walk due to his left heel wounds, and that at one point the wounds were "down to the bone." On 8/9/06 at 3:00 p.m. the administrator stated Resident #1 had an infection on his left heel when he was admitted, and the wound had not healed. On 8/10/06 at 12:00 p.m. a caregiver stated Resident #1's heel wounds had not healed, even though they had been soaking the resident's left foot in Epsom salts, applying urea cream, and encouraging the resident to wear a foam boot on his left heel for comfort. On 8/10/06 at 3:15 p.m. the administrator, upon further inquiry, stated she was told by the medical providers Resident #1's heel wounds "would never heal" due to the poor blood supply to the foot. On 8/10/06 at 3:30 p.m. the facility nurse stated Resident #1 has had the heel wound for six months and that it has stayed the same "for a long time." She further stated she thought the doctors were happy the wound had stayed the same, and they had said there was nothing more they could do for the wound. The facility retained a resident (Resident #1) who had open wounds that were not improving bi-weekly.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 4 II. Negotiated Service Agreement 1. Review of Resident #1's record on 8/9/06 revealed the resident was admitted on 9/27/05 with diagnoses which included alcohol abuse, congestive pulmonary disease, alcoholic dementia, and cataracts. Further review of Resident #1's record revealed a UAI dated 10/25/05 which documented the resident needed moderate assistance with meal preparation and extensive assistance with medications. Further review of Resident #1's record revealed an NSA dated 10/17/05 which documented the resident needed extensive assistance with meal preparation and medications. The NSA did not document the services to be provided, the frequency of such services, and how the services were to be delivered related to care of the resident's dentures, the resident's refusal to eat, or the resident's significant weight loss. a. Weight Loss Review of the Resident #1's record on 8/9/06 revealed an initial nurses's assessment dated 10/20/05 which documented the resident weighed 189 pounds. Also, the resident had no teeth. Resident #1's record also contained monthly nursing assessments which documented the following: On 11/22/05 the resident's weight was not taken; the resident was eating well.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 5 On 12/22/06 the resident weighed 180 pounds. On 1/24/06 the resident weighed 174 pounds, and the resident was not eating well, because he did not like the foods served. On 2/17/06 the resident weighed 170 pounds. On 3/20/06 the resident weighed 158 pounds, and staff reported the resident had not been eating well. On 4/20/06 the resident weighed 144 pounds, and the resident refused to eat, "except what he wants." On 5/16/06 the resident weighed 144 pounds; and the resident had new dentures, but refused to wear them. On 6/27/06 the resident weighed 142 pounds; continued to refuse to wear his dentures. On 7/28/06 the resident weighed 145 pounds; continued to refuse to wear his dentures after visiting the dentist for readjustment. Review of the facility's daily logs revealed a "Weight Chart" for Resident #1 dated from 3/22/06 through 8/9/06. It was documented on the log the resident weighed 151 pounds on 3/22/06, and 140 on 8/9/06. The resident's weight documented on the log ranged between 151 and 145 pounds from the end of March through the month of April, and between 146 to 140 during the months of May, June, July and August. On 8/10/06 at 8:15 a.m. Resident #1 was observed eating breakfast. The meal offered to	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 6 the resident consisted of two fried eggs, two slices of white bread toast, and a bowl of dry cereal with milk. The resident was eating the cereal. He stated, "There's no meat in here," as he pointed to the plate. On 8/10/06 at 12:10 p.m. Resident #1 was observed at lunch. The meal offered to the resident consisted of a small amount of mashed squash, a small pork chop, a small portion of rice pilaf. The resident had pushed his plate away and was eating a quarter of a slice of watermelon. On 8/10/06 at 9:30 a.m. a caregiver confirmed Resident #1 did not eat very well. On 8/10/06 at 3:05 p.m. the administrator confirmed Resident #1 had lost weight. Further she stated, Resident #1 did not eat well, would not wear his dentures and wanted to eat Southern cooking. Additionally, she stated there had been no consultation with a registered dietitian about Resident #1's weight loss. b. Monitoring of Medications Resident #1's record contained physician's orders dated 6/30/06 which documented Resident #1's urea topical cream, which was to be applied to Resident #1's heel and bottom of feet twice daily, was discontinued. On 8/10/06 Resident #1's July and August 2006 MAR were reviewed. The MAR's revealed Resident #1 received urea cream on the following dates and times: 7/2/06 at 8:54 p.m. 7/3/06 at 1:25 p.m. 7/4/06 at 9:00 a.m.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 7 7/4/06 at 9:01 p.m. 7/5/06 at 9:04 a.m. 7/6/06 at 8:47 a.m. 7/6/06 at 8:44 p.m. 7/7/06 at 8:36 a.m. 7/8/06 at 9:50 a.m. 7/8/06 at 8:16 p.m. On 8/10/06 at 10:46 a.m. the administrator confirmed Resident #1 had received urea cream after the medication was discontinued, and she confirmed the physician's order to discontinue the urea cream was not followed. Further, she stated she had instructed the caregivers to continue the urea cream on an as needed basis after it had been discontinued, because of Resident #1's difficulty in adjusting to change. 2. Review of Resident #2's record on 8/9/06 revealed the resident was admitted on 1/13/04 with diagnoses, which included hyperthyroid, osteoarthritis, left rotator cuff tear, dementia, dyspepsia/gastroesophageal reflux disease and heart arrythmia. Further review of Resident #2's record revealed a UAI dated 2/22/06 which documented the resident became confused when in familiar surroundings, was confused to time and situation, had deteriorating cognitive function, needed more cuing with activity of daily living, and had difficulty with short term memory loss. Additionally, the UAI documented Resident #2 required extensive supervision with all medications, was not able to identify medications and could not remember if he took his medications. Further review of Resident #2's record revealed an NSA dated 6/28/05. The section entitled "Behavioral Management/Interpersonal Needs"	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 8 documented "none at this time." Additionally the NSA documented the resident required total assistance with medications. Further review of Resident #2's record revealed no documented evidence of a BMP to address Resident #2's wandering from the facility. a. Behavior Management Further review of Resident #2's record revealed monthly nursing assessments which documented the following: On 5/16/06 Resident #2 had "reverted to the past" by focusing on horses, cows and other farm animals for which he cared earlier in his adult life, the resident had increasing behaviors of trying to open the exterior doors of the facility, and the resident wandered into other resident's rooms. On 7/28/06 Resident #2's mental status had "deteriorated markedly" over the past several months, the resident was less talkative, and the resident could no longer respond appropriately to simple requests, such as squeezing and gripping his hands. Additionally, the assessment documented the resident continued to focus on horses. Review of the facility records revealed "Staff Communication/Observation Reports" which documented the following: On 7/5/06 Resident #2 wandered out of the facility and was waiting for a ride out in the parking lot. On 7/21/06 Resident #2 was not able to find his room.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 9 On 7/25/06 Resident #2 attempted to walk out of the facility when a caregiver left at 2:00 p.m. The resident thought the caregiver was his wife and he needed to go with her. On 7/27/06 Resident #2 wandered outside, behind the facility, and he said he was trying to find his horses. On 7/28/06 Resident #2 was observed by caregivers pushing on the exterior doors to get out of the facility. He said he wanted to go and get his horses. On 8/9/06 Resident #2 wandered out of the facility into the parking lot. He said he wanted to go and get his horses. On 8/9/06 at 11:05 a.m. Resident #2 was observed wandering the hallway and going into another resident's room. Shortly thereafter the other resident told the resident to leave using an irritated tone of voice. On 8/9/06 at 12:15 p.m. Resident #2 was observed being dropped off in front of the facility. The resident stood alone in front of the facility and looked from side to side. Resident #2 then walked off the sidewalk away from the front door of the facility. At that time, the administrator came out of the facility and escorted Resident #2 back inside the facility. On 8/11/06 at 10:15 a.m. Resident #2 was observed standing in the anteroom between the inner door and the outer door of the entrance of the facility with his hand on the door handle. No facility staff were in the immediate vicinity.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 10 On 8/10/06 at 2:20 p.m. a caregiver stated that since last summer Resident #2 had wandered into adjacent fields surrounding the facility property looking for his horses and other farm animals. This was an ongoing problem and had become more frequent over the last month. Further, she stated Resident #2 had wandered out of the facility the last two evenings and had been found in the parking lot. On 8/10/06 at 3:05 p.m. the administrator confirmed Resident #2's mental status had been deteriorating over the last four or five months. Additionally, she confirmed she had not developed a BMP. b. Monitoring of Medication Review of Resident #2's record on 8/9/06 revealed a physician's order dated 3/22/05 for Lotrisone cream sparingly BID to affected areas for two weeks PRN. On 8/10/06 Resident #2's MAR for March 2005 through August 2006 revealed the resident was assisted with Lotrisone cream on the following dates: 5/20/05 at 8:00 p.m. 5/23/05 at 8:00 p.m. 6/10/05 at 10:30 a.m. 6/18/05 at 10:30 a.m. 8/3/05 once (untimed) 8/6/05 once (untimed) 8/10/05 once (untimed) 8/12/05 once (untimed) 5/10/06 at 10:07 a.m. 6/12/06 at 10:42 a.m. On 8/10/06 at 3:00 p.m., the administrator	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 11 acknowledged resident had received Lotrisone cream after it was discontinued. 3. Review of Resident #3's record on 8/9/06 revealed the resident was admitted on 5/5/06 with diagnosis that included developmental disability, anxiety, bipolar disorder, hypertension, and non insulin dependent diabetes. Further review of Resident #3's record revealed a UAI dated 3/8/06 which documented the resident needed medications monitored by the facility. Further review of Resident #3's record revealed an NSA dated 6/20/06 which documented the facility would assist the resident with medications on a daily basis. a. Monitoring of Medications Resident #3's record contained physician's orders dated 7/26/06 which documented the resident's metoclopramide 5 mg one tablet by mouth four times a day was discontinued. Review of Resident #3's July and August 2006 MAR revealed the resident received metoclopramide on the following dates: 7/27/06 at breakfast, noon, 5:00 p.m., bedtime 7/28/06 at breakfast, noon, 5:00 p.m., bedtime 7/29/06 at breakfast, noon, 5:00 p.m., bedtime 7/30/06 at breakfast, noon, 5:00 p.m., bedtime 7/31/06 at breakfast and noon 8/1/06 at breakfast and noon On 8/10/06 at 10:46 a.m., the administrator confirmed Resident #3 had received metoclopramide after the medication was discontinued.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R773	A. BUILDING _____ B. WING _____	08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALLIS ASSISTED LIVING FACILITY - CUSTE	1050 N CLINIC RD CHALLIS, ID 83226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 12 The facility retained a resident who had an open wound that was not improving bi-weekly. Additionally, as the NSA's were not complete for Residents #1, #2, and #3, the facility could not implement an NSA that provided guidance to personnel in their provision of care and services to meet the needs of the residents. These failures resulted in inadequate care.	R 008		

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

RECEIVED
SEP 11 2006
FACILITY STANDARDS

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Challis Assisted Living Facility	1050 N. Clinic Rd.	(208) 879-3030
Administrator	**City**	**ZIP Code**
Lavon Rhodes	Challis	83226-1050
Survey Team Leader	**Survey Type**	**Survey Date**
Polly Watt-Greier	Standard Survey	8/11/06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	16.03.22.250.14	The facility did not provide a secure interior or exterior environment for residents with cognitive impairments (#2, #4)	Interior 8/26/06 Exterior DELAYED
2	16.03.22.250.15	The facility did not have a operational call system.	DELAYED
3	16.03.22.305.02	The facility's nurse did not assure residents medications were current for 3 of 4 residents (#1,2,3).	8/30/06
4	16.03.22.310.01	Staff other than the licensed nurse filled medication blister packs.	8/28/06
5	16.03.22.320	The NSA's for 2 of 4 residents were not completed or signed within 14 calendar days of admission (#1,3).	8/14/06
6	16.03.22.320.08	The NSA's were not reviewed every 12 month or with change in condition (#1,2,4)	DELAYED
7	16.03.22.505.01b	The facility did not document each transaction of the resident's personal funds to include signatures of facility personnel and the resident(#1).	8/16/06
8	16.03.22.630.01,02,03	2 of 3 staff did not receive specialized training in the areas of dementia, mental illness, and developmental disability.	8/16/06
9	16.03.22.711.08a	The facility did not document refusal of care or services for 2 of 4 residents (#1,3).	9/01/06
10	16.03.22.711.09	The facility did not maintain a current list of medications as prescribed by a physician or authorized provider.	8/28/06

Response Required Date	Signature of Facility Representative
9/11/06	LaVon Rhodes